# Clark County
# Regional Support Network
# Home Health Care Authorization

Date: _____/_____/_____

Consumer's Name: _____

DOB: _____/_____/_____ Sex: _____ SS# _____-_____-_____

Open CRMHS Client: Yes _____ No _____ ID # _____

If **No**, referral to CRMHS made by: _____

Notes: _____

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Hours Authorized: _____ Start Date: _____/_____/_____ Cert. #: _____

❑ Negotiated Diversion (See case notes) ❑ Denial (See case notes)

Initials: _____